NOTE: Sample health form that can be adapted for use by local advisors

MISSOURI ASSOCIATION OF FAMILY, CAREER & COMMUNITY LEADERS OF AMERICA
Medical Release Form

I, _____ of _____
Parent/Guardian Name Address
_____ am the _____ of _____
City State ZIP Relation Member's Name
of_____ .
City State ZIP

I hereby give my consent, in the event all reasonable attempts to contact me have been unsuccessful, for immediate medical treatment as required in the judgment of the attending physician while_____ is absent from home _____ to _____ .
date date

Member's Date of Birth: _____ Social Security Number (optional): _____

Parent/Guardian Phone Number(s):Work:(____)_____ (____) _____

Home:(____)_____ (____) _____

Family Physician:_____ Family Dentist:_____

Address: _____ _____
Street Street

_____ _____
City State ZIP City State ZIP

Phone:(____)_____ (____) _____ (____) _____ (____) _____
Work Home Work Home

Medical Insurance Company _____ Policy Number:_____

Name of Insured: _____

The following information is needed by any hospital or practitioner not having access to a medical history:

Allergies:_____

Medication being taken:_____

Date of last tetanus shot: _____

Physical impairments:_____

Other pertinent facts to which physician should be alerted:_____

_____

_____

(over)

If parent/guardian cannot be reached in case of emergency, call:

_____ (_____) _____
First Choice Name Area Code Phone

_____ (_____) _____
Second Choice Name Area Code Phone

In a medical emergency, I consent to the local/state advisor or appointed agent, his, her or their discretion in using, taking, arranging for or consenting to the procedures or treatment.

I agree to indemnify and hold harmless the Missouri Association Family, Career and Community Leaders of America, the individual members, agents, employees and representatives thereof, for any and all claims, demands, actions, rights of action, and/or judgments by or on behalf of the above named member arising from or on account of said procedures and/or treatment rendered in good faith and according to accepted medical standards.

I assume the total financial responsibility for the above named members and will not hold the Missouri Association Family, Career and Community Leaders of America responsible in the event of a medical emergency.

_____ _____
Signature of Parent/Guardian Date

_____
Social Security Number of Parent/Guardian (optional)